

FILED AUG 1 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 24619
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3208

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 522 Bellfontaine		d. STREET ADDRESS (If outside, give location) 522 Bellfontaine	
3. NAME OF DECEASED (Type or print) ELLEN R. HOLWELL		4. DATE OF DEATH Month July Day 9 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 8, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Companion Nurse		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (City and state or country) Lexington, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Martin Murphy		13b. MOTHER'S MAIDEN NAME Mary Moran	
14. NAME OF HUSBAND OR WIFE Joseph Holwell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 263 12 0965		17. INFORMANT Miss Mary Cavanaugh	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Neovascularization Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility		INTERVAL BETWEEN ONSET AND DEATH 331 X	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION Lexington, Missouri		20g. STATE Missouri	
21. I attended the deceased from 1900 to 7-9-67 and last saw her alive on 7-8-57 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Hugh A. Gestring M.D. (Degree or title)	
22b. ADDRESS 1220 E 31st		22c. DATE SIGNED 7-10-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-11-57	
23c. NAME OF CEMETERY OR CREMATORY CALVARY Cemetery		23d. LOCATION (City, town, or county) (State) Lexington, Missouri	
24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home		25. DATE RECD. BY LOCAL REG. 7-10-57	
26. REGISTRAR'S SIGNATURE Neal Minshall		27. EMBALMER'S STATEMENT ON REVERSE SIDE	

1800 E. Linwood, Kansas City, Mo.

Dr. Huggins
1220 E. 31st
Va 1-640
12 nov 23

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4912

P. O. Address K.C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.